EXHIBIT A

EXCERPTS FROM THE DEPOSITION OF RAHUL GUPTA, M.D.

04/15/2021

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF WEST VIRGINIA

* *

THE CITY OF HUNTINGTON,

Plaintiff,

vs. CIVIL ACTION
NO. 3:17-01362

AMERISOURCEBERGEN DRUG
CORPORATION, et al.,

Defendants.

CABELL COUNTY COMMISSION,

Plaintiff,

vs. CIVIL ACTION
NO. 3:17-01665

AMERISOURCEBERGEN DRUG
CORPORATION, et al.,

Defendants.

* *

Videotaped and videoconference deposition of RAHUL GUPTA, M.D. taken by the Defendants under the Federal Rules of Civil Procedure in the above-entitled action, pursuant to notice, before Teresa S. Evans, a Registered Merit Reporter, all parties located remotely, on the 15th day of April, 2021.

You put them up on the -- for the doctor to see and then he can comment on them.

But we don't have printouts right here of all the exhibits.

MS. MAINIGI: Okay. Steve, are you --

MR. RUBY: I thought -- sorry, Mark, I thought you guys were going to have them printed for -- for doctor Gupta.

MR. COLANTONIO: Yeah, I apologize if that was a -- I didn't -- I just don't have them here, Steve. But I think -- I think if you put them up that he'll be able to, you know, do it that way.

MR. RUBY: Well, let's do this. Let me --

MS. KEARSE: Yeah, Steve, I thought you were doing them remotely as well. We just -- and we didn't get copies of them.

MR. RUBY: Hold on. Let me --

MS. MAINIGI: Well, while -- while we gather up some of the exhibits, I think, Steve, we'd want to -- I'm not even sure we need 51, but I guess 58 would be one of the next ones.

BY MS. MAINIGI:

Q. So Doctor Gupta, let's just go ahead and jump in. Is it correct that you worked in West Virginia from approximately 2009 to 2017?

A. That is correct, but that is not the entirety of my experience in West Virginia.

Q. What other experience did you have in West Virginia beyond -- beyond the experience of those years?

A. I had worked in West Virginia from March of 2009 to November of 2018. And after that, I continued to be a volunteer physician to date with West Virginia Health Right, which is a charitable clinic in Charleston, West Virginia.

Q. And is that something you do through today, Doctor Gupta?

A. Yes.

Q. And how often do you volunteer as a physician at that clinic?

A. I would take advantage of every time I'm able to or most times I'm able to visit West Virginia, to be able to do that. That could be ranging anywhere from once a month to once every few months.

Q. And that has happened since your departure

from West Virginia in approximately November of 2018. Is that correct?

A. I have volunteered in my time since my departure from West Virginia in November of 2018.

Q. And your present position, Doctor Gupta, is being the chief medical officer at the March of Dimes; is that correct?

A. My current position at March of Dimes is chief medical and health officer, as well as the interim chief science officer, and senior vice president --

Q. I'm sorry, you cut out there, Doctor. Senior vice president of what?

A. Of March of Dimes.

Q. Did you take the role at the March of Dimes beginning in approximately 2018?

A. Yes.

Q. And you moved to the Washington, D.C. area around that time?

A. I did not move immediately to the Washington area.

Q. Did you commute for some period of time?

A. Yes.

Q. When did you move to the Washington, D.C.

area?

A. Probably around February or March of 2019.

Q. Doctor Gupta, the March of Dimes is a global organization focused on maternal and infant health; is that correct?

A. Yes.

Q. And the March of Dimes works on prenatal education, among other things. Is that correct?

A. That would be part of the work that we do at March of Dimes.

Q. And also professional education?

A. That would be accurate as well.

Q. And also NICU support and resources?

A. That would also be accurate, NICU standing for neonatal ICU.

Q. Thank you. And also health equity, Doctor Gupta?

A. That would also be correct.

Q. And a fairly extensive medical research agenda? Is that correct also?

A. That would be correct.

Q. And the work that the March of Dimes does, that's done on a global basis, true?

A. The work of March of Dimes historically and

currently is done both at domestic levels as well as international level.

Q. Now, while at the March of Dimes, Doctor Gupta, you are not acting as a specialist in addiction treatment, correct?

A. That would be correct.

Q. You're not acting as a specialist in pain management, correct?

A. That would be correct.

Q. You're not a specialist in neurobiology, correct?

A. Could you please repeat that last one?

Q. Sure. You are not acting as a specialist in neuro -- neurobiology, correct?

A. Could you please explain? I'm not -- no, I mean, I don't understand the question about a specialist in neurobiology. There's no - to my knowledge - a physician position of being a specialist in neurobiology.

Q. Okay. Thank you. And you're not acting as a specialist at the March of Dimes in epidemiology, correct?

A. That would be incorrect.

Q. That would be incorrect?

A. That's correct.

Q. Okay. Could you explain to me how you are -- what your role is as a specialist in epidemiology at the March of Dimes?

A. My work that includes the title of the chief medical and health officer as well as the chief science officer often involves the engagement of the principles of epidemiology, biostatistics, policy, which are all part of my training as well as my experience and expertise.

Q. Do you act as a specialist in epidemiology in -- at the March of Dimes, Doctor Gupta? Or do you interact with epidemiologists?

A. I am the person that is in charge and not only in charge of other epidemiologists, but I am the person that other epidemiologists look to for expert advice.

Q. And do other epidemiologists look to you for epidemiology advice?

A. That's correct.

Q. In what areas, please?

A. In areas of epidemiology.

Q. And can you give me specific areas, please?

A. Areas of maternal health, infant health,

population health, health policy, biostatistics. I can go on.

Q. Do you have any training in epidemiology, Doctor Gupta?

A. I have both training and experience.

Q. Do you have -- let me ask this first: Do you have any formal training in epidemiology?

A. Yes.

Q. What is the formal training you have in epidemiology?

A. Beyond my medical degree where I had extensive training in public health and epidemiological practices of five and a half years, I have a master's in public health from University of Alabama-Birmingham.

Q. Have you ever held yourself out as an epidemiologist when you were practicing medicine, Doctor Gupta?

A. I do not understand the nature of the question. Could you please rephrase?

Q. Sure. You have a -- you have training in internal medicine, correct?

A. Correct.

Q. And I -- as I understand it, for some

period of time, you were in private practice and you held yourself out as an internist. Correct?

A. Amongst other areas as well, correct.

Q. And my question to you then, with that background, is: Have you ever held yourself out as an epidemiologist and solely an epidemiologist?

A. I still do not understand the nature of the question of being a physician solely as an epidemiologist. I can help to answer the question this way: That as the local health officer and physician director, which is the official position at Kanawha-Charleston Health Department, my role from March of 2009 to December of 2014 - which was almost six years - involved leading a team of epidemiologists in a variety of work that included conducting epidemiological surveys, studies, analysis and policy making as a result of that work for the largest county in the state of West Virginia, which is Kanawha County.

Following that, because partly of that work, the Governor of the state of West Virginia asked me to serve as the State Health Officer, which also requires to have - similar to Kanawha-Charleston Health Department - a

significant experience and expertise in epidemiology in order to serve in that position.

So both of those positions, from March of 2009 to November of 2018, required significant expertise in epidemiology as -- as per stated in statute for the State of West Virginia and the policies of Kanawha Charleston Health Department.

Q. Okay. We'll come back to that time period.

MR. RUBY: Enu, not to interrupt, but we are set up to screen share the exhibits whenever you want.

MS. MAINIGI: Oh, terrific.

Q. Speaking of West Virginia, when you were in West Virginia, did you ever live in Huntington?

A. No.

Q. Did you ever live in Cabell County?

A. No.

Q. Did you ever work in Huntington?

A. Yes.

Q. And when -- from when to when did you work in Huntington?

A. My work as the health commissioner for the State and the State Health Officer required me to ensure that my work involved not just in Kanawha

County, but for all 55 counties and all the cities within the jurisdiction of the State of West Virginia.

That work involved a number of activities, including visits, as well as epidemiological work, investigatory work, regulatory work, as well as other facets that included Cabell County as well as the City of Huntington.

And part of my job was to not only work with the public health department, but also the elected and other officials from Cabell County and the City of Huntington.

Q. How often do you think while you were in that role, Doctor Gupta, that you visited Huntington or Cabell County?

A. Could you please define the time period?

Q. The time period that you were State commissioner.

A. I would visit the City of Huntington and Cabell County, broadly speaking, anywhere from, you know, once every couple of weeks to once every couple of months.

Q. Were -- was there a system at the

Commission of keeping track of where you traveled? Was there a log or something that was maintained?

A. I'm sorry, which commission?

Q. Well, let's see. You became the State -- you're speaking about the State health commission, correct? In that role as the State Health Officer, you visited Cabell and Huntington. Right?

A. No, Ms. Mainigi, I was the Commissioner of the Bureau of Public Health at the West Virginia Department of Health and Human Resources, which is -- also provides the -- by statute, the position of the State Health Officer, so I'll just step back a little bit and help to -- help --

Q. That's okay. I -- not to interrupt you, but thank you for that clarification. So let me just keep going. While you were the Commissioner of public health, that's when you made somewhat periodic visits to Cabell and Huntington, correct?

A. That is not the only time.

Q. Okay. Well, let's stick with the time you were in that role. You mentioned that you ranged from one time every couple of weeks to one time every couple of months, correct?

A. Yes.

neurobiology?

A. Once again, I'm not aware of particular licensing around neurobiology physicians.

Q. And once again, you would say, Doctor Gupta, that you did act as a specialist in epidemiology while you were executive director; is that right?

A. That would be accurate.

Q. And do you have any licensing in epidemiology?

A. I'm -- I'm not sure -- which particular licensing are you asking about?

Q. Well, to your knowledge, is there licensing that exists for epidemiology?

A. I am not aware of a physician specialty through the Board of Medicine that is exclusive for epidemiologists' practice.

Q. So you're not aware of any licensing related to epidemiology.

A. I'm not aware of any specialist licensing in the medical practice of West Virginia that provides that type of licensing.

Q. Okay. And what about outside of West Virginia? Are you aware of any medical

organizations that license in epidemiology?

A. I would not be aware at this time of any particular organizations. Knowing that the practice of medicine is regulated by State Board of Medicine, not outside organizations, in the State of West Virginia.

Q. Now, in 2014, you became the State Health Officer for West Virginia, correct?

A. I'm sorry, could you repeat that, please?

Q. In 2014, you assumed the role of the State Health Officer for West Virginia?

A. That would be incorrect.

Q. Tell me how it's incorrect.

A. I assumed the role in January of 2015 of commissioner for the Bureau of Public Health at DHHR and the State Health Officer.

Q. Let me just go back to the epidemiology point. Are you aware of an organization called the American College of Epidemiology?

A. Not -- that doesn't sound like an organization that I have worked with.

Q. So if you haven't heard of it, you're not a member of it, I assume.

A. I don't think I'm a member of it.

Q. Now, your role that you assumed in January of 2015 as the State Health Officer for West Virginia, I assume that had a wider range of duties than the duties you had at Kanawha Charleston, correct?

A. That would be accurate.

Q. And so as the State Health Officer, as I understand it, you oversaw more than 130 separate programs; is that right?

A. That would be accurate, and just wanted to add so -- in case -- I know you probably didn't mean to miss this out on purpose, but during that time, I was also the health officer and physician director for Putnam County Health Department as well, part of the time that I was in Kanawha County.

That's -- and by the way, just to -- for your knowledge, that's the connection county between Cabell and Kanawha. You have to drive through Putnam County to get to Cabell.

So during that time also - going back to your previous question - I was in the most contiguous county next to Cabell and the City of Huntington, and that was another level of

he's able to finish his questioning regarding your questions about this document.

So I think it's quite appropriate now that he's reviewed it. You didn't let him review it while he was on the record, so he's now reviewed it, so if he just --

MR. COLANTONIO: I just want to place on --

MS. MAINIGI: Okay, Doctor --

MR. COLANTONIO: Hold on a second. I want to place on the record that I object to your statement that somehow there's a rehearsed answer, and I take umbrage to that, and just for the record, I want to put that on the record.

MS. MAINIGI: Okay, understood.

BY MS. MAINIGI:

Q. Doctor Gupta, could you please pull out Exhibit 58 again? I don't know if your counsel has printed it out for you now, but it is -- it is the statement that they filed with the Court with all of your opinions that has led to this deposition.

Let me know if you just want it on the screen, and we are happy to leave it on the screen.

A. It's already on the screen.

Q. Okay, terrific. I'm going to ask you about the first bullet, and that first bullet reads as follows: "Opiate prescription drugs, their volume, and the consequential addiction and other diseases associated with OUD rose by thousands of percent over a decade."

Did I read that correctly?

A. That's what it says.

Q. Do you agree with this statement?

A. I'm not sure if I agree with the entirety of the statement.

Q. Okay. What part of the statement -- and I don't need the reasons yet, we can break that down, but what part of the statement do you agree with or disagree with?

A. I don't agree with the statement, period.

Q. Okay. So let me just ask you one follow-up question on that and then we can move on to another opinion of yours. Where it says "thousands of percent over a decade," do you have any idea what decade is referenced there?

A. Ms. Mainigi, you're providing me this document. I don't have -- you know, I'm -- you're asking me a question if I agree to the statement.

I said I don't agree with the statement. So you're welcome to ask me questions, but I can't guess what you're thinking.

Q. Okay. Do you recall making this statement at your last deposition?

A. I do not.

Q. Okay. So you don't know what -- just for the record, the word "decade" in that statement, the first bullet, you don't know what decade is being referred to there.

A. I would request to you once again, after the break now, that if you intend to show me a statement, please provide me the context, because it's really unfair and misleading for me to be able to react to a statement without having any context, and you're doing it again.

Q. Okay.

MS. KEARSE: Enu, if you want to show him the page numbers on the deposition --

MS. MAINIGI: I don't. I'm just going to go off of this document that you all filed on his behalf, Anne.

Q. Okay. So let's move on to --

MS. KEARSE: You referred to his

BY MS. MAINIGI:

Q. Doctor Gupta, I'm going to show you Statement No. 3, Bullet No. 3 of Exhibit 58.

MS. MAINIGI: Steve, could we scroll down to it, please?

MR. RUBY: Yep. There's a little lag here. Sorry.

MS. MAINIGI: Sorry.

Q. Okay. Doctor Gupta, why don't you take a moment and read that? Let me know when you're ready.

A. Okay.

Q. Okay. Statement 3 reads, "There is a direct correlation between diverted prescription pills and the transition to using street drugs such as heroin, fentanyl, methamphetamine, etc." Do you agree with this statement, Doctor Gupta?

A. Yes.

Q. And what is your basis for this statement?

A. Well, it's both the literature that exists to support that as well as my experience and the opinions that have resulted from my experience.

Q. Okay. Can you give me specific literature references that would support that statement,

Statement 3?

A. Sure. You know, as -- I think back as 2014, Theo Cicero actually published a 50-year analyses in general psychiatry that showed that, you know, as much as 75 to 80 percent of the transition that was happening in people who were using heroin was actually -- they were the people that were in fact looking at -- nowadays, were transitioning from prescription drugs, as opposed to the '60s where 80 percent of people were going in the opposite direction.

So there's been a lot more literature since that that shows about 80 percent of the people that use heroin today have had their start from prescription opioids to begin with.

Now, having said that, we saw very similar facts in West Virginia. We started to see people that were often - because of a large volume and diversion that resulted often in addiction were utilizing prescription drugs, and as there was more policy and actions that were being taken to address that - part of that was reduction in supply - these people really often, as an example, when there was action on shutting down a pill mill, there were

often people that would then not have a supply.

As a result of that, they would either have two or three options. One option was to go to the emergency room. We saw flooding of the emergency room.

Second was to go to street drugs which were much more readily available, cheap in terms of heroin, or just die, overdose and die.

And we were seeing all of this. So our findings matched what was being published. In fact, there's been some work done by Sarah Mars in Philly population that also showed very similar numbers, and we were matching that up.

So as that began to happen, more and more people transitioned to heroin, there began an infiltration of cutting heroin with fentanyl by drug dealers primarily to save costs, to make more money.

And as that was happening, fentanyl, of course, is a substance that's about 80 times more potent than morphine, so because it was uncontrolled, we were seeing batches of deaths happening together because of bad batch of fentanyl-cut heroin.

Across West Virginia, that was the case. When we had in 2016, fall of 2016 or so, an outbreak in Huntington, West Virginia that was first but not the only of its kind across the country, where in a matter of hours, dozens of people were overdosed and had to be taken to the hospital.

This was an example of where disease from overdose was starting to simulate an infectious disease, meaning you have a patient zero and -- or -- which would actually be a drug dealer that would have a bad batch, and that many people would get impacted.

Same thing happened in Beckley during my tenure, and other places as well.

So that -- that first phase was prescription drugs. The second phase, because of increased volume -- the volume, diversion and addiction was actually getting it on.

And the action that followed was to transition to heroin. That was wave two, as CDC describes it.

The third wave was actually mixing of heroin with synthetic opioids like fentanyl, and I

but you've got leftover pills presumably lying around. Fair?

A. The two-thirds approximately on the survey that was reported was often -- were prescriptions, prescription drugs - so we're only talking about the prescription drugs at this point - that people have brought home.

Now, these could be legitimate prescriptions; they could be illegitimate prescriptions.

And -- but if those that are flooding the population because of the large volume that happens. So someone had a -- you know, I use a tooth pulled example. But you could use a cataract example, but something for a one-time event but somebody got 30 days with three refills, well, that's going to lay around and that's going to get into the hand of children -- hands of children or somebody else, for all types of purposes, and that's the diversion.

Now, on the other hand, when somebody gets it for a legitimate prescription and also either goes and sells it or misuses it or gives it to somebody else to misuse, that's also diversion.

So -- and then obviously diversion leads to addiction which leads to the constant need to have some sort of opioids in your system that when those volumes start to shrink, people transition to other types of alternatives.

Q. Now, you are aware, Doctor Gupta, are you not, that the vast majority of people who use prescription opioids do not become addicted to street drugs?

A. I'm sorry, could you repeat that, please?

Q. Sure. Do you agree that studies demonstrate that the vast majority of people who use prescription opioids do not become addicted to street drugs?

A. We're talking about two very different populations, so I'm not sure of the correlation. Are you talking about -- I need to have more data on that.

Q. Okay. In your experience then, as a practicing physician as well as the various roles you've held in West Virginia, do you agree that the vast majority of people who use prescription opioids do not become addicted to street drugs?

A. What time frame are we talking about? I'd

like to -- you know, like I said, I'd like to know more about that.

Q. The time frame that you held the positions in West Virginia that we've been discussing.

A. That's not what I'm asking you. I'm asking what -- for what duration of prescription opioids do those people use, and for what purpose? Because context is important.

Q. During the -- the vast majority -- do most people use prescription opioids for long-term periods?

A. So in 2012, United States, we had 255,000,000 prescriptions. That was 80 prescriptions for 100 people across the country. I hope that answers my question -- your question.

Q. Well, why don't we -- so you don't have -- I'll just ask you one more time. You -- from your experience, you don't have an opinion on whether the following statement is true or false. The -- and the statement is: "The vast majority of people who use prescription opioids do not become addicted to street drugs."

A. According to the 2016 March guidelines for chronic pain from the Centers for Disease Control

and Prevention, use of prescription drugs, opioid prescriptions, for more than five or seven days, puts you at a very high risk for addiction.

Q. For addiction to that prescription drug, correct?

A. For addiction -- for the disease of addiction. Period.

Q. Let's go to Statement 4. Why don't you take a moment and read it.

A. Okay.

Q. Okay. Statement says, "Once an addiction is formed, an individual struggling with addiction will obtain the addictive substance by any means necessary, which often results in illegal activity and the use of illegal substances."

Do you agree with that statement?

A. Here's what my opinion is: I believe that once someone is suffering from substance use disorder, that individual is struggling with a disease, is -- has a actual chronic relapsing disease, and it becomes then very important that that individual is offered the help in order to treat that disease, just like we would do for diabetes or cancer or anything else.

Going untreated, there are a number of risks to that individual that include all the way from -- from suffering from disease, other mental health conditions, to all the way to death.

Q. Doctor Gupta, I'm going to explore some of what you just told me in a minute. But before we do that, can I just ask you to look at statement -- the statement that's marked 4 and tell me whether, as written, whether you agree with it or disagree with it.

A. I'm not sure I have an opinion about that statement, the way it's written.

Q. Do you know what percentage of people struggling with addiction do illegal things to support their addiction?

A. I don't have a percentage at this time.

Q. Do you know what percentage of people who become addicted to prescription opioids go on to use other illegal substances?

A. From the data that I've highlighted prior, it's -- what we know now is about 80 percent of people who are using heroin got their start from using prescription opioids.

Q. That is not the question I asked. Right?

A. That is the answer.
Q. What percentage -- I'm sorry?
A. That is exactly the answer I provided, so --
Q. That's the only figure that you have then. Fair?
A. Well, I'm happy to rephrase it if you have -- you know --
Q. Well, let me ask you the question again, just in case I misunderstood your answer. Can you tell me what percentage of people who become addicted to prescription opioids go on to use other illegal substances?
So this is the percentage of people who become addicted to prescription opioids.
A. So to my previous statement, I think by phrasing the question the way you have, you're discounting the thousands of West Virginians and hundreds of thousands of Americans who have actually perished as a result of addiction, and I think it's an unfair question to ask that way.
Q. Okay. I will take from your answer that you don't have a number, Doctor Gupta. Let me move on to your Statement No. 5, if I could. Let's move

we include illegitimate prescribing; we include diverted in the sense of borrowing, stealing, purchasing, all of those things.

Q. Have you done any independent analysis - besides relying on this study that you referenced - to determine if this 80 percent number is applicable to Cabell County?

A. As I've stated, that's my opinion to a reasonable degree of certainty.

Q. And my question is: Have you done any independent research to determine if that 80 percent number is applicable to Cabell County?

A. I can't recollect at the time, so I can't say yes or no. I just don't -- I don't remember at this point.

Q. And do you remember whether you did any independent research in the City of Huntington to determine if that 80 percent number is applicable to the City of Huntington?

A. No, I don't think I -- I can't recollect. But also, you know, we have 55 counties in the state, first of all. Second, there was an outbreak of overdose, and I can't recollect at this time the exact findings of the outbreak in 2016.

So that's another resource for you to go and look at if you -- if you're willing to.

Q. By the way, the 80 percent number that you cite, what study does that come from?

A. That's -- a number of people have done that. So the Theo Cicero, as I mentioned, JAMA Psychiatry. It's something that has generally been accepted. You know, I can help -- I can provide you the specific resources. But Theo Cicero found, I think, about 75 percent.

And I think most -- most of the data has usually quoted 80 percent.

Q. But you recall -- the one you're specifically recalling is Cicero.

A. Yeah. Cicero had 75; I think Sarah Mars may have 80. But that's an agreed-upon -- and I want to say with a reasonable degree of certainty that CDC utilizes that number as well.

Q. The CDC uses that number as well. Okay.

A. Yeah. I -- I want to say -- again, I'd have to -- if I was allowed to look at it, I would look at the stats. But you know, we're not in that phase right now.

Q. And what stats would you be looking at

besides the ones you've mentioned, Doctor Gupta?

A. I would be confirming my statements that CDC numbers --

Q. Let's shift to Statement 11, if we could. Why don't you take a moment and read that.

MR. RUBY: This spans two pages, Doctor, so let me know when you're ready to --

THE DEPONENT: Okay. Go ahead, please.

MS. MAINIGI: Steve, there's no way to get both pieces in?

MR. RUBY: Let's see. We might be able to shrink it. There we go.

MS. MAINIGI: There we go. You're such a pro, Steve.

BY MS. MAINIGI:

Q. Okay, Doctor Gupta, Statement 11 reads as follows: "Although there was a 15-20% reduction in opioid prescriptions in 2015 and 2016, there was no reduction in overdose deaths because the addiction had already been formed and people with opioid use disorder were turning to illicit, more lethal forms to feed their addictions that was initially formed by prescription opioids."

late '90s, early aughts. One was an ethical reason, the doctors had an ethical obligation to reduce patients' pain down to zero. Is that fair?

A. I don't think I said that doctors -- I said the manufacturers, you know, and others created a system or an environment where physicians were made to feel that there was an obligation to bring everyone's pain down -- across America, down to zero level.

And the pills that we were provided should be provided liberally, and there is no problem, there's no addiction, there's no side effects of those pills.

So that was a -- that was a -- the effect that was created. Purposefully, now we know.

But -- and clearly organized medicine was engaged in that.

Q. And so the efforts that were made in West Virginia in 2015, '16, '17 were to help counter balance that through the physician population.

A. The efforts were to educate prescribers - not just physicians, all prescribers - for Schedule II to ensure that they understood what good

practice guidelines are for pain. They understood the risk of addiction, especially with longer -- higher doses and longer durations, and they were more judicious in prescribing.

And for those who already were suffering from substance use disorder were able to seek the help that they could so they do not overdose and they do not die.

Q. Let's switch gears to Statement 19, Doctor Gupta. It's --

MS. MAINIGI: Let's scroll down to that.

A. Okay.

Q. That statement reads, "Addiction tells people to seek opioids in one form, shape or other." Do you agree with that statement?

A. I would -- I would say it this way: It's my opinion that substance use disorder makes people seek substances to continue to feed the habit because there's a constant need for Dopamine in the -- in the brain.

So -- and then people would do - in the grips of addiction - as a result, what they need to do to continue to seek those substances.

Q. What is your basis for this opinion, Doctor Gupta?

A. The basis for my opinion is my training in medicine; my experience, 25 years of practice of medicine; and with a reasonable degree of certainty, as well as my understanding of the science of addiction and substance use disorder.

Q. Do you have any research papers that you can cite to me as support for this statement?

A. Sure. You can probably -- there's a PBS documentary on Nova called "Addiction." They have featured the director of the NIDA, National Institute of Drug Abuse, a few addition -- an addiction psychiatrist and myself, to talk about addiction.

And you're welcome to see that. That's kind of one aspect. But then I'm happy to get you textbooks for addiction or papers or otherwise. But this is the -- the science of addiction, while developing and evolving, this is what we understand today in medicine.

Q. Now, you are not an expert in addiction psychiatry, correct?

A. That's correct.

Q. You're not an expert in neurobiology?

A. I don't know what that expertise is, as I said before.

Q. Let me go back to one of the things -- one of the statements we were discussing previously, Doctor Gupta. When there was a reduction in the levels of opioid prescriptions in the 2015-'16 time period, were you surprised? Were you and your colleagues surprised that heroin overdoses increased?

Had you anticipated a decline in drug overdoses as the prescribing levels dropped? Or was -- was that something that did come as a shock to you?

MS. KEARSE: Objection.

Q. Let me -- let me ask the question again to avoid objection. You referenced a reduction in the levels of opioid prescriptions in that '15-'16 time period. Correct, Doctor Gupta?

A. Yes.

Q. When you saw the reduction in opioid prescriptions in that time period, were you surprised that heroin overdoses increased?

A. So we know again that opioid prescribing

So we created protocols where via doctor letters would go to in that area or that county before a pill mill was about to be shut down around that time.

We created educational resources. We created all of these protocols. So we were working closely with federal, state and local law enforcement behind the scenes so that when that action took place, you didn't just see police officers and people being taken to jail, like bad doctors and their staff.

But then we worked behind the scenes to make sure those people would have resources to go to so they don't end up being on the street and using IV heroin. They don't end up flooding the emergency room or they don't end up, worse enough, dying.

So those are the actions that we took.

Q. I'm going to ask you to move to Statement 20. Statement 20 reads, "Chemically speaking, synthetic opioids, semi-synthetic opioids and the prescription opioids work through the same receptors and feed the same need to the body." Do you agree with that statement?

A. Yes.

Q. You're not an expert in addiction sciences, you've already said, though, correct?

A. I'm not an addiction psychiatrist.

Q. Have you done any research on the effects of various opioid substances on the brain?

A. I've not conducted any lab research on the effects of opioids on the brain.

Q. Let's go backwards to Statement 12. Statement 12 reads, "The increase in overdose deaths in West Virginia during that time was caused by the large volume of opioid pills that were originally deposited or delivered to West Virginia."

Do you agree with this statement?

A. That is my opinion.

Q. What is the time period that you would agree that this statement is true?

A. I would say at the beginning of 2000-2001 to date.

Q. Now, you don't mean by the statement that prescription opioids were the sole cause of the increase in opioid deaths, do you?

A. Could you repeat that, please?

Q. Sure. You don't mean by this statement that prescription opioids were the sole cause of the increase in opioid deaths, do you?

A. If I heard you correctly, you said, "the prescription opioids were the sole cause of opioid overdose deaths." Is that what you're asking me?

Q. I'm asking you whether you think that prescription opioids were the sole cause of the increase in opioid deaths.

A. Prescription opioids were a substantial factor in the significant rise in overdose, drug overdose, deaths in West Virginia.

Q. Now, was the criminal distribution of heroin a cause?

A. Heroin certainly -- heroin cut with fentanyl was also a cause. But just to remember, that was driven from prescription drugs, prescription opioids, transitioning.

Q. What are some of the other causes?

A. So there's often not a one-to-one relationship. What that means is, what we were finding, that an average decedent had anywhere between three and five substances in their body. What would they be? They could be

And all of the doctors - meaning the birthing physicians in Cabell County and all across West -- across West Virginia, agreed to a common definition. Once we did that, we then started to capture that definition and those diagnoses in a program called Birth Score out of West Virginia University.

We worked very closely with experts in Marshall, at Marshall University, to measure the amount of NAS that was happening. And I'm using NAS intermittently with NOWS, which is neonatal opioid withdrawal syndrome, and we then characterized the rate of NAS per county, and we found that the average rate of NAS in the state was 5 percent. That's 1 in 20 babies, which is the highest by far of any state in the nation.

But we also found that some of the counties had much higher rate, to the tune of 10 and over 10 percent. Again, that's a published report, available in the public domain. And I -- I don't have a -- you know, a lot of recollection about every aspect of it.

Q. Do you remember who within your organization primarily did the research for that

report?

A. It would have been the -- under my supervision, the Department of Family and Children's Services.

Q. Statement 21. Let's turn to that for a moment. "Children diagnosed with at birth have noticeable difficulties learning and paying attention." Do you agree with that statement?

A. Once again, diagnosed with NAS is what's missing here, but if we could put "with" blank, because that's just -- it's an error in the statement.

Q. Okay.

A. So -- yeah.

Q. So with that "NAS" added, do you agree with that statement?

A. Yes.

Q. Now, you don't have any training in neonatology or pediatrics, correct?

A. Actually, I have had rotations during my training in pediatrics and neonatology.

Q. When you were a resident; is that correct?

A. When I was in medical school, and I don't remember if it was residency too. But I've also

done emergency room coverage that included -- as well as my primary care practice, that included children.

Q. Okay. And that includes neonatology as well?

A. I have not taken care of NICU babies, so no.

Q. Have you done any research on the incidence of attention or learning deficits in children diagnosed with NAS?

A. Not personally, I have not.

Q. Do you know what percentage of children diagnosed with NAS exhibit noticeable difficulties learning and paying attention?

A. We are just at the precipice and that data is evolving, so I can't tell you for certain what that percent is.

(Background noise.)

MS. MAINIGI: If someone is off mute, could you please go on mute? I hear some background or interference. Is there a --

MS. KEARSE: Someone needs to be put on mute.

(A discussion was had off the record

after which the proceedings continued as follows:)

BY MS. MAINIGI:

Q. Doctor Gupta, do you have any studies or reports that would support the statement in 21 that you --

A. Yes.

Q. -- can give me?

A. Yes.

Q. What are they?

A. There's a number of reports, including -- if you go to the CDC website, and that clearly talks about some of the challenges in learning as well as memory development, cognitive development as a consequence of NAS.

Q. Now, can you tell me what percentage of NAS diagnoses result from prescription opioid use versus illicit opioid use?

A. Once again, very similar to people who die and you cannot tell in them because the metabolites are the same. To the developing baby, it doesn't really matter whether it's prescription or otherwise, so --

What I can tell you is: We did

studies in West Virginia at Bureau of Public Health and we found that one out of five babies' cord blood had a substance positive. That was with -- that was inclusive of prescription as well as illicit.

We also found that almost 15 percent of intrauterine exposure was positive for substances. And I believe that was prescriptions.

But once again, I don't have access to that data right now, so I cannot be 100 percent certain at this point.

Q. The one-out-of-five statistic, was that something that was published by --

A. Yes.

Q. -- by who?

A. We have published that. So the first study was published by -- by one of the neonatologists - we funded the study at CAMC - Doctor Stefan Maxwell.

Q. 22, "As children with NAS enter the classroom, there will be noticeable, interruptive and impulsive behavioral issues." Do you agree with that statement?

A. Yes.

Q. Are you making that statement as a mental health professional?

A. I'm making that statement as a Commissioner who has interacted with hundreds of teachers, school board members and parents and has learned a lot through interacting with actual West Virginians on the ground.

It is my opinion with a reasonable degree of certainty that children, as they're growing up who are diagnosed initially with neonatal abstinence syndrome have a significant difficulty oftentimes with impulse control, with focus in classroom issues and may sometimes get misdiagnosed as ADD.

Q. Do you -- besides your own experience talking to teachers and so forth, do you have any studies that you can cite to?

A. Yes. So there's a lot of literature. I'm happy to share with you. Some of the folks that have worked on this is people like Stephen Patrick at Vanderbilt and others. That literature is there and is evolving and includes - which is not mentioned here - some of the birth defects as well of children with NAS.

Q. Okay. And let's go back to No. 8. No. 8 reads, "The opioid epidemic has lead to an increase in the number of children entering the foster care system, rapidly increasing child welfare costs to the state." Do you agree with that statement?

A. Yes.

Q. Now, the foster care system in West Virginia was the responsibility of a different part of DHHR than your office; is that correct?

A. That's correct.

Q. You did not oversee the foster care system, did you?

A. I did not.

Q. Where did -- what's your basis for this statement then?

A. In addition to being the Commissioner of the Bureau for Public Health, as I mentioned before, I'm also -- I was also the State Health Officer. That being, it was my responsibility in that role to be overseeing the -- you know, number of other aspects of the public health system.

So we interacted frequently with and worked closely with -- with the -- that particular department, as well as our parent department, which

is the Department of Health and Human Resources, as I -- and I reported to my boss, which is the Cabinet Secretary.

Now, clearly I was open to looking at the data for the foster care system, and saw and experienced in our budget presentations to the legislature each year that we worked together with the commissioners who create that, and we reported on this.

The Cabinet Secretary is on the record stating in his testimony - where I was present - that about 90 percent of the cost of foster system in West Virginia is associated in some form or other with the opioid crisis or the substance use disorder crisis.

So that's something that is on the record from my boss, and of course, it's my opinion based on that and some of the budgetary and other factors and working closely with the -- my co-agency, that this statement holds true with a substantial -- and again, a reasonable degree of certainty.

Q. So opioid prescription medications require a prescription; is that correct?

A. Not always. As we discussed, that people do not need to have a prescription in order to have access to prescription opioids when -- especially when the volume in a community is overwhelming.

Q. Well, to legally obtain prescription opioids, you need a prescription, correct?

A. Correct.

Q. Okay. You can't buy them over the counter, correct?

A. Correct.

Q. And the prescription must be written by a health care provider who is licensed by the State and registered with the DEA, correct?

A. Correct.

Q. And it must be dispensed by a pharmacist who's also licensed by the State and registered with the DEA, correct?

A. Correct.

Q. And no prescription opioid can leave a pharmacy lawfully unless a doctor decides to prescribe the prescription and a pharmacist decides to dispense the prescription, correct?

A. Incorrect.

Q. And why is that?

A. Because doctor is not the only prescriber. You could have other prescribers as well.

Q. Fair enough. So let me ask it again then. So a prescription opioid cannot lawfully leave a pharmacy unless a doctor or other qualified prescriber decides to prescribe the prescription and the pharmacist decides to dispense the prescription. Correct?

A. Correct.

Q. Your Statement No. 2, let's go to that for a moment, please. "The amount of appropriate prescriptions was dwarfed by the amount of inappropriate prescriptions that were being diverted." Is that a statement you agree with?

A. Yes.

Q. What do you mean by the term "inappropriate prescription"?

A. Prescriptions could be - as I mentioned here, or you can see here - is appropriate prescription. That means there are criteria in which it might make sense to prescribe opioids. In other situations, it may not make sense to prescribe opioids, and in those situations, you know, we would call that inappropriate prescribing.

So getting 30 days of Vicodin for a tooth pull would be an example of inappropriate prescribing. Seeing 100 patients in a day without doing appropriate background, looking at patients, understanding their history, doing a physical exam, is another example of what we consider pill mill or inappropriate prescribing in a large volume.

So these are some of the -- you know, dentists, others that -- you know, I said, cataract, an ophthalmologist prescribing 30 days of prescription, is an inappropriate example.

So that's my -- but someone who has -- is -- has terminal cancer and has exhausted any other options, is on opioids, well controlled, is an example of appropriate prescribing for opioids.

So that's my description between "appropriate prescription" and "inappropriate prescriptions."

Q. You're not an expert in pain management, correct?

A. I have served on some panels in terms of the West Virginia SEMP panel and others. I have provided training and talks to the State-level conferences. But I have not received any formal

training on pain management beyond my residency training and beyond my ex -- sort of expertise of 25 years of managing private care physicians, primarily where we were the ones that were -- became the target of writing these prescriptions.

So that would be my answer.

Q. Your definition of "inappropriate", as I heard it, Doctor Gupta, may include prescriptions that were written legally, correct?

A. Correct.

Q. And it could include, in fact, millions of prescriptions that were written legally, correct?

A. Sure.

Q. And your definition of "inappropriate" may also include prescriptions that were within the standard of care that existed at the time they were written, correct?

A. They may or may not be.

Q. Give me an example of a prescription that you would call "inappropriate" but that was written within the standard of care for the time.

A. So the standard of care did not require -- strike that.

We had ample evidence to demonstrate,

through studies, that opioids do not help control or improve function in chronic pain, yet millions of prescriptions were being written for chronic pain for opioids. That's an example.

Q. And at some point in time, at least, prescribing opioids for chronic pain was within the standard of care, correct?

A. One can argue that, but the fact of the matter is that opioids as a first line of therapy for chronic pain were never standard of care.

So prescribing opioids in high volume, in high doses, high strength, as a first line for chronic pain, without any other alternatives, I don't understand to be the standard of care.

Q. And so what did West Virginia do about that through the Board of Pharmacy, the Board of Medicine or any other institution within the state of West Virginia?

A. Clearly, as I mentioned - I'll go from -- you know, from now to backwards - when the 2016 CDC guidelines came out in March of 2016, we assembled a panel at the Department of Health and Human Resources. We brought together all the experts, including insurers, exec -- you know,

diseases, it says "OUD rose by thousands of percent over a decade." And I want to show you just what I was -- what I think where we looked in the transcript, and maybe we can clarify whether it's thousands or, you know, substantial.

But you were asked some questions about addiction, and this is on page 324, and you were -- and I don't know if you'll recall this, and this is just a very quick just section of your transcript.

But you were talking about that alcohol challenges did not rise by a thousand of percent when you were asked about alcohol and you were trying to -- you were testifying to the extent if it's different with the opioid with that too, and with the opiate prescription drugs and volumes that did rise, it's followed by the thousands.

If you'll just read that and maybe we can just clarify whether it's thousands or a substantial rise on that. We can look at --

MS. MAINIGI: Objection to form.

Q. Okay. So let me ask you this -- if you'll read -- we cited in the disclosure to the actual page number, and on page 324 and 325, we -- you

testified that to now take that out "wouldn't be fair because alcohol -- alcoholism and alcohol challenge did not rise by thousands of percent over a decade. Opiate prescription drugs and volume" did rise.

So let me say if we took out "thousands," and maybe that's where you're not comfortable. And I can ask you that question. What in Bullet Point No. 1 are you not comfortable with in regards to your opinion?

MR. HESTER: Objection to form.

MS. MAINIGI: Objection to form. Objection, Ms. Kearse, to you testifying and trying to put words in the mouth of this witness. This witness has already testified that he did not object -- that he did not agree with this statement, Statement No. 1.

MS. KEARSE: And I can ask him what is it he does not agree with?

A. Yes, so the -- my deposition of September 2020 very accurately describes what I meant to say. And I'll say that again for the record. What I said was that the opioid prescription drugs and the volume of prescribing has risen by thousands of

percent over a decade. And I stand by that.

Q. Okay, Doctor. And that -- that would reflect -- is there anything else in No. 1 that you -- that you have issue with, the addiction and others associated with OUD rose as well?

MS. MAINIGI: Objection to form.

A. I'd have to read it again.

Q. Okay.

A. So you know, again, in public health epidemiology, if -- you know, just because a thousand people take a bad batch of drugs doesn't mean everybody dies. A few people will die, a few will be really, really sick. I mean, we can use the pandemic right now as an example. Not everybody who gets the infection from COVID dies or ends up in a hospital.

Some people will be fine. Others will end up in a hospital. Some will end up on a ventilator, and others will die. Just like that.

When a prescription volume increases by thousands of percent, then obviously there will be a proportional increase in OUD. That doesn't necessarily have to be thousands of percent. But people suffering from it would clearly be way more

STATE OF WEST VIRGINIA,
COUNTY OF JACKSON, to wit;

I, Teresa S. Evans, a Notary Public within and for the County and State aforesaid, duly commissioned and qualified, do hereby certify that the foregoing deposition of DR. RAHUL GUPTA was duly taken by me and before me at the time and place and for the purpose specified in the caption hereof, the said witness having been by me first duly sworn.

I do further certify that the said deposition was correctly taken by me in shorthand notes, and that the same were accurately written out in full and reduced to typewriting and that the witness did request to read his transcript.

I further certify that I am neither attorney or counsel for, nor related to or employed by, any of the parties to the action in which this deposition is taken, and further that I am not a relative or employee of any attorney or counsel employed by the parties or financially interested in the action and that the attached transcript meets the requirements set forth within article twenty-seven, chapter forty-seven of the West Virginia Code.

My commission expires October 15, 2030.

Given under my hand this day of April, 2021.

Teresa S. Evans
RMR, CRR, RPR, WV-CCR

STATE OF WEST VIRGINIA

COUNTY OF KANAWHA, to wit;

I, Teresa Evans, owner of Realtime Reporters, LLC, do hereby certify that the attached deposition transcript of DR. RAHUL GUPTA meets the requirements set forth within article twenty-seven, chapter forty-seven of the West Virginia Code to the best of my ability.

Given under my hand this 19th day of April, 2021.

Given under my hand

Registered Professional
Reporter/Certified Realtime Reporter